

**TIFFIN CITY SCHOOLS  
STAFF EMERGENCY MEDICAL AUTHORIZATION**

Staff Member's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ School \_\_\_\_\_

**Purpose** - To enable staff members to authorize the provision of emergency treatment for themselves if they become ill or injured while at school, when spouse or relative cannot be reached.

**PART I – TO GRANT CONSENT**

In the event reasonable attempts to contact \_\_\_\_\_ at \_\_\_\_\_  
(name) (phone no.)

or \_\_\_\_\_ at \_\_\_\_\_ have been unsuccessful, I hereby  
(name) (phone no.)

give my consent for (1) the administration of any treatment deemed necessary by Doctor \_\_\_\_\_ (preferred physician) or Doctor \_\_\_\_\_ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of myself to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the staff member's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_  
(signature of staff member)

**PART II – REFUSAL TO CONSENT**

I do **not** give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish authorities to take the following action: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

DATE \_\_\_\_\_  
(signature of staff member)

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